CALIFORNIA MENTAL HEALTH
STIGMA & DISCRIMINATION REDUCTION ADVISORY COMMITTEE

February 3, 2009 Meeting Summary

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1. Welcome and Agenda Review

Julia Lee, Facilitator from the Center for Collaborative Policy (CCP), Sacramento State, welcomed people to the fifth meeting of the California Mental Health Stigma and Discrimination Reduction Advisory Committee (AC for short), held at the Sacramento State Alumni Center in Sacramento. Julia noted several subject matter experts who would be joining the Advisory Committee for small work group, and encouraged them to introduce themselves with a few words about their expertise.

Julia reviewed the meeting objectives and walked AC members through the day's agenda, which was focused on identifying recommended actions related to systems and organizations for the plan. All the day's materials are posted online on the AC's website, http://www.dmh.ca.gov/PEIStatewideProjects/AdvisoryCommittee.asp

Julia pointed to a form for AC members to sign up for offline work groups to develop recommended actions via teleconference, and a save-the-date notice for the Public Workshops in March. She noted that a final flyer will be distributed at a later date. Julia also introduced a set of ground rules for the small group discussions.

2. Work Group Reference Document & Annotated Update Review

Julia directed AC members to the Work Group Reference Guide and the Annotated Bibliography, Version 3, as new references to bring into and guide small group discussions, in place of a presentation. Both the Work Group Reference Guide and the Annotated Bibliography were shaped by research suggestions from Advisory Committee members, and each document is divided into sections by Work Group topic. AC members were then directed to refer to a yellow worksheet also included in their packets; Julia explained that the next twenty minutes were

allotted to give AC members time to review the new resources, and frame their themes and recommended actions for the two work groups they would join later in the day.

3. Developing Actions for Systems & Organizations

Julia went over the small group work that the AC members would engage in for the rest of the day. This involved self-selecting into two work groups targeting specific systems and organizations, and having extended small group discussions focused on generating actions for these systems. Each group had a facilitator and a recorder. There would be two sessions over the course of the day, and people could switch groups between the first and second. Only Mental Health System, Schools, and Media would be covered in both sessions.

The nine systems and organizations work groups included:
(1) Schools: K-12
(2) Medical System
(3) Mental Health System
(4) Housing
(5) Employment and Workplace
(6) Media
(7) Law Enforcement
(8) Law, Public Policy, and Legal System
(9) Faith Based Organizations

One additional work group, Higher Education, did not meet, but a small work group of volunteers from the Advisory Committee and subject matter experts will convene outside of the regular meetings.

The appendix contains a full list for the recommended actions generated by each work group. Some additional notes are included when relevant. Julia explained that all work group members would be provided with an opportunity to review and add comments to draft recommended actions before they were included in the notes. NU is this process still accurate? If not, just delete this last sentence…a little bit of post-meeting revisionist liberty.

4. Gallery Walk

After each small group was completed, AC members and guest subject matter experts walked around the Alumni Center and reviewed the actions that had been written on large paper posted on the walls. In some cases, additional actions were added with Post-it notes.

5. Wrap Up, Homework, Meeting Evaluation

Dorian Fougères, Assistant Facilitator for the Center for Collaborative Policy (CCP), reviewed the Save-the-Date flyer distributed in the agenda packets. A teleconference will take place on Monday, March 16, from 5 pm to 6:30 pm; the toll-free number is 1-800-230-1092, and public workshops will be held on Tuesday, March 17, from 1 pm to 4 pm in Emeryville, and Thursday, March 19, from 1 pm to 4 pm in Santa Ana. Both locations are accessible by public transit, and

special needs will be accommodated as requested. The flyer will be sent out to the Advisory Committee as soon as language translations for Spanish, Vietnamese, Cantonese, Russian, and Armedian [NU note I took out the term threshold because it is a specific term and actually there are I think 12 in california] are finalized, so the Advisory Committee may outreach to their respective communities and interested parties. The online registration will be translated as well, available at http://www.dmh.ca.gov/PEIStatewideProjects/AdvisoryCommittee.asp. Advisory Committee members asked if we have the ability to videotape the workshops, and if travel costs would be reimbursed, to which Dorian replied that CCP would check with DMH and get back to the Advisory Committee.

Susan Sherry, Executive Director of the Center for Collaborative Policy (CCP) then led the AC in evaluating the meeting.

PLUS	CHANGE
+ Brainstorm and dialogue was good	Δ Comments on comments
+ Facilitators	Δ Coffee in the afternoon
+ Responsible—Implementation	

The next meeting is Tuesday, March 3, 2009 and will be held again at the Sacramento State Alumni Center.

7. Attendance

Committee Members:
Khatera Aslami
Delphine Brody
Rocco Cheng
Rob Chittenden
Kita Curry
Natalia Deeb-Sossa
Fran Edelstein
Pia Escudero
Luis Garcia
Marty Giffin
Lisa Harris
Elisa Herrera
Stacie Hiramoto
Janet King
Matt Lord
Daniel McCarthy
Arnulfo Medina
Karen Moen
Sabirah Mustafa
Marie Nitz
Stephanie Ramos
Dede Ranahan
Sean Rashkis
Cuco Rodriguez
Gregory Sancier
Ron Schraiber
Diane Shively
Alysa Solomon
Sheryle Stafford
Philip Traynor
Arcadio Viveros
Sue Watson
Jennifer Whitney-Tucker

Public:
Lin Benjamin
Jane Christol
Hope Holland
Maryann Leshin
Barbara Lurie
Danny Marquez
Robert Martinez
Joyce Mitchell
Zach Olmstead
Darwin Olson
Jason Robison
William Romero

Stuart Seaborn
Al Venegas
Michelle White

DMH, OAC, and CCP Staff:
Ariel Ambruster, CCP
Cielo Avalos, DMH
Jordan Blair, DMH
Kirsten Deichert, DMH
Dorian Fougères, CCP
Julia Lee, CCP
Christal Love, CCP
Sam Magill, CCP
Jodie Monaghan, CCP
Sarah Rubin, CCP
Susan Sherry, CCP
Nicole Ugarte, CCP
Joan Waters, CCP
Beverly Whitcomb, OAC
Sue Woods, CCP
Tina Wooton, DMH

Appendix A: Recommended Actions for Systems & Organizations

I. Schools: K-12

INTRODUCTION

Members of the work group felt this topic should include, at a minimum, preschools, if not other programs serving children ages 0-5. In addition, it should cover Adult Ed, which is offered by school districts.

Relevant concepts and action Items generated in January by the Work Group on Children are affirmed and incorporated.

Educational institutions and educational employees are often unfamiliar with the continuum of health concept and are unschooled in cultural competency. Because of this, interactions by teachers or school staff with students experiencing social, emotional or behavioral challenges, or with students from minority communities, may increase those students' experience of isolation and social exclusion and harm their school performance. Extra outreach efforts may be needed to reach these students if they fall out of the system.

These students may be treated differently by other students at school, and may be subject to acts of aggression and violence. Incorporation of mental health literacy, anti-stigma and cultural competency material in the K-12 curriculum can help educate members of the student body and help reduce the perpetuation of harmful stereotypes.

Support systems for students experiencing social, emotional or behavioral challenges, as well as for parents, siblings and family systems of these students, and teachers, can help build self-esteem and relationships and reduce stigma.

Efforts to help such students can be undermined by lack of communication and collaboration between different institutions, such as the mental health and school systems, or schools and law enforcement.

ACTIONS

I. TEACHER/STAFF EDUCATION

A. Establish state credential requirements and training programs to educate new and existing teachers on the continuum of health concept and cultural competency.

1. Work with the California Commission on Teacher Credentialing to add mental health credential requirements for teachers and administrators. Utilize a mental health curriculum produced by DMH. In making these changes, make sure to get buy-in from the California Teachers Association and any other key stakeholders.
2. Develop ongoing training through salary point classes on a continuum of mental health.
3. Develop cultural competence education for both teachers and staff to reduce chances that expectation will negatively affect student performance, and to reduce the risk of ethnic children, or children in the minority, feeling isolated or out of sort. These feelings have led to mental illness in Native and other children.
    a. Example: The PBS series "Unnatural Causes…is inequality making us sick?" talks about the "Latino paradox" – immigrant families show better health when they've first arrived. The longer time they are here, the less connected they are to their culture of origin and they experience an increased risk factor for mental disturbance.

B. Ensure that support is provided for teachers at the school site.

1. Ensure teachers have on-site support groups.

II. CURRICULUM FOR STUDENTS

A. Develop and incorporate mental health concepts into the state curriculum.

1. Develop a mental health literacy curriculum for K-12, with a grade/age appropriate anti-stigma program at each grade level.
2. Mandate mental health issues in all state curriculum areas, both for students and teachers.
3. Produce a handbook/primer for mental health literacy and combating stigma for school health education programs.
4. Develop programs that include components for students to teach mental health curriculum themselves, so they feel invested. Youth learn what they teach better than being told.
5. To better prepare graduating students entering the workforce or educational systems, incorporate in the curriculum an integrated wellness/recovery model approach that encompasses the "whole" person through the continuum of care.
6. Educational tools could include games and CD-ROMs, which are both educational and entertaining.

B. Ensure that California school curriculum and materials do not perpetuate stereotypes about different cultures, which can lead to school failure and mental health problems.

1. Develop and incorporate cultural competency concepts into the curriculum. The curriculum should reflect the strength of a student's or community's cultural roots. Research has proven (Unnatural Causes) that people culturally rooted are less at risk for mental illness.
    a. Example: A Native American student who challenged the use of a book in

class that referred to Native Americans as "savages" and had other stereotypical language was told by the teacher that she would not stop using the book, but that the student could be excused from class while it was being used. Later, the school produced a play based on the book, and once again, the student was removed from that activity. Such approaches produce feelings of exclusion. This student later developed mental health issues.

b. Resource: Oyate.org is a resource for educators to include Native American perspectives in the curriculum. Anti-native curriculum has often been the source of first break for Native American children exhibiting mental disturbance. See oyate website.

2. Assure funding and resources to enable schools to utilize existing cultural competency programs.

C. Involve teachers, students and staff in curriculum development.

1. Include teacher participation in curriculum development.
2. Involve students, as curriculum recipients, in curriculum development.
3. Involve staff as well, with the intent of positively affecting entire school cultures.

D. Develop curriculum resources and a support system.

1. Create a clearinghouse hosted by the Department of Education website, including resource materials for students, teachers, parents and others, as well as best practices.
2. Ensure students have self-help support groups.
3. Create vocational tracks so all students are valued.

III. STUDENT SUPPORT

A. Develop mental health support programs for students with social, emotional and behavioral challenges.

1. Create support groups for kids who are victims of bullying.
2. Create clubs for mental wellness -- students can get support without having to go to groups.
    a. Example: Gay Straight Alliances
3. Create pullout programs to build self-esteem and relationships.
4. Develop after-school and lunch programs on cultural strength, values and wellness
5. Develop mentor programs.
6. School student support teams should include youths, so that students have a peer to relate to, and do not feel targeted or ganged up on.
    a. Examples: youth advocate, peer mentor.
7. Develop programs that provide role models of those who have overcome
8. Include a leadership component in all student support services so students learn to become active agents of change.
9. Provide support for students in dependency/foster care systems who may be at higher risk.
10. Create a safety net for young adults (who are under 18, but are still "children" and need parental involvement) so they don't fall through the cracks.
11. Develop counselor training for awareness/support for transitional age youth and

those "aging out" of foster care/dependency in late high school.

12. Make resources available everywhere at school: classroom, library, lunchroom, hallways. Youth will get used to seeing mental health resources, and this will normalize getting help.
13. Hold higher education institutions accountable for appropriate student mental health services
14. Involve students who are not un/underserved.
15. Embed mental health services in school health programs.
16. Use existing annual data from California Healthy Kids surveys to prepare information for students on subjects such as bullying, violence, substance abuse and depression that they want and need. Data is there already -- use it!

IV. DIFFERENT LANGUAGE

This theme for schools incorporates the following concepts (with amendments as underlined) developed by the Workgroup on Children at the January 14, 2009 meeting:

The language of mental illness does not help children/adolescents with social, emotional, and behavioral challenges. Using such labeling reinforces discrimination, which in turn reinforces denial, fear, and shame on the part of families and self-stigma on the part of these children/youths. Rather than use mental illness language, it is more helpful and accurate to describe these children and adolescents as experiencing social, emotional, or behavioral challenges.

Additionally, describing mental health along a continuum of wellness helps normalize children's and youths' social, emotional, and behavioral challenges and is a particularly helpful concept for families trying to understand their child's problem. The mental health continuum concept can be used on a universal basis for all children and adolescents, and thus, is an important and responsible tool for reducing stigma and discrimination.

Lastly, it is very important that the California Plan for Mental Health Stigma and Discrimination Reduction model language that is supportive of children's and adolescents' healthy development and resilience and address their mental health issues separately from stigma and discrimination toward adults.

A. Incorporate these concepts about mental health language into the state schools curriculum.

V. EDUCATE AND SUPPORT PARENTS/SIBLINGS/FAMILY SYSTEMS

A. Develop educational programs for parents on childhood mental health issues.

1. Provide early education for parents. Support their participation in these programs by providing childcare and other services.
2. Expand well baby kits to incorporate social and emotional development, as well as information on resources.
3. Enhance school readiness materials to include mental health (address the whole child) and substance abuse.
4. Link to the American Pediatrics Association for two-way outreach and education.

B. Develop support programs for parents, siblings and family systems of children with social, emotional and behavioral difficulties.

1. Create organizations like the Regional Centers to support families.
2. Develop self-help support groups for families.
3. Support the development of a culture of parent/teacher partnerships.
4. Create outreach strategies such as peer outreach and parent facilitators.
5. Ensure outreach addresses stigma to support families seeking/needing help. Include parents with young children as one target of outreach. Utilize PSA's, media, brochures in outreach.
6. Utilize a learning model.

VI. MONITORING AND ACCOUNTABILITY

A. Develop monitoring and accountability systems in education at the state and local levels to ensure that school-related mental health programs are efficiently achieving their assigned goals.

1. Ensure that the state Education Code is compliant with the Mental Health Services Act, including both regular and special education.
2. Create a monitoring/accountability group at the state level. This group should include broad representatives of interest areas, including possibly the California Teachers Association, the American Federation of Teachers, county superintendents, the Department of Education, the Department of Mental Health, the statewide PTA, student representatives (high school age), a governing body of the mental health/psychology field, and Peace Officers Standards and Training.
3. Publish an accountability report card.
4. Ensure more parent involvement in monitoring and accountability at all levels.
5. At the local level, develop a student monitoring/accountability component. It may be possible to use existing advisory boards.
6. Student representation in monitoring/accountability efforts should include more than one student so that there is shared learning and experience.

VII. INNER SYSTEM COLLABORATION, CONFLICT

A. Create a place where people can bring collaboration and conflict.

1. Develop a committee, working group or other entity, such as an ombudsman's office, that serves to support collaboration and is a place to bring conflict.
2. Use a "system of care" approach with the same language. Find a term for this approach other than "system of care" or other mental health system terminology.
3. Re-institute/expand AB3015 to be a continuum.
    a. Evaluate various models for this program.
    b. Use a model that incorporates powerbrokers.
    c. Consider for possible Prop 63 funding.

VIII. AWARENESS

A. Enhance communication and understanding between the educational and mental health systems.

1. Develop programs to ensure that administrators in the educational and mental health

systems each become familiar with what is happening in the other system and develop an understanding of the other system's language.
2. Develop programs to educate mental health administrators about the challenges that schools and teachers face and to encourage mental health system support for educational system goals of academic achievement and success.
3. Educate teachers and administrators.
4. Promote collaborative partnerships.

B. Develop programs to increase awareness about mental health issues.

1. Develop awareness programs that include content about restraint, seclusion and the effects on children.
2. Educate officers about stereotypes, especially in regards to violence, i.e., people identified as mentally ill are not, in essence, more dangerous than the general population. Include content about others such stereotypes, such as incompetence.
3. Develop school speaker programs featuring: 1. Youths who have experienced mental health problems; 2. Broad presentations by youth or younger adults who have successfully dealt with mental health issues, discussing self-esteem, wellness and cultural values.
4. Develop awareness programs to promote/uplift/encourage the successes of individuals with mental health challenges.
5. Develop materials written by or featuring youth.
    a. Example: National Mental Health Awareness Campaign
6. Utilize communication avenues to best reach young people, including new media materials such as podcasts.

IX. SEARCH AND SERVE

A. Develop programs to reach students with mental health challenges who have fallen out of the system.

1. Use previous search and serve programs as a model. Expand and improve the language and approaches.
2. Ensure the following groups are among those targeted: immigrants, refugees, the homeless, runaways.
3. Establish a student services support team at every school that includes a nurse, psychologist, counselor, social worker and student peers.
4. Use peer advocates (students trained to identify and assist youth and refer them to higher care if needed) to help connect with all youth and help through transitions to high school.

X. LAW ENFORCEMENT INTERACTIONS

Group members, after their discussion, agreed that a number of the below items might be incorporated in the Law Enforcement Group's list of actions.

A. Increase collaboration and coordination between education, law enforcement and other institutions and interests.

1. Encourage collaborative partnerships with schools, staff, clinicians, parents, PTA's and juvenile probation toward enhanced quality of life for K-12 kids.
2. Create a culture in which police and members of law enforcement are seen as a

support and resource, especially for kids being stigmatized.

B. Encourage programs that increase knowledge and understanding among law enforcement, youth and individuals with mental health issues,

1. Encourage crisis intervention training (CIT) for all. Develop training programs for law enforcement, presented by community members, on youth behavior, including youth with mental health issues.
2. Develop presentations by community members to youth about police criteria for killing/using force with youth, so youth can modify behavior.
3. Fund more mental health crisis response units.
4. Provide support and evaluation for officers' mental health state of mind.
5. Provide trauma-focused treatment, evaluation and education for police officers, who may be suffering from PTSD.
6. Develop programs in which police with mental health issues serve as role models for treatment.
7. Develop presentations by members of crisis intervention teams.

XI. EMPLOYMENT/CAREER DEVELOPMENT

A. Increase career-related linkages between schools and the mental health sector that incorporate stigma and discrimination reduction content.

1. Develop "magnet" programs to funnel high school students into mental health jobs. Make sure these programs have a critical focus on stigma and discrimination reduction.

Develop school-business partnerships.

II. Medical System

INTRODUCTION

In today's society, a clear dichotomy exists between physiological (i.e., "medical) health care and mental health care. Medical care receives significant funding from the state and federal government even though the medical system is *primarily* privately owned. Mental health care receives less funding, and is typically among the first services to be reduced during budget crisis. Creating parity between medical and mental health training requirements, funding levels, and public perceptions is vital to reduce stigma and discrimination against mental health consumers. This will allow all patients (whether medical or mental health) to achieve "wellness" instead of physical or mental health only.

Specific actions and suggestions related to mental health stigma and discrimination include the following:

Training

The workgroup determined that additional training for doctors, nurses, and consumers about mental health issues and peer support options is the best way to address stigma and discrimination in the medical system. It was commonly agreed that all training include consumers wherever possible. Specific actions included:

- Develop mental health training for primary care physicians, including medical school and mandatory continuing education units (CEUs). Emergency room rotations in particular should include mental health training.
- Review the adequacy of training assessments/testing for psychiatrists.
- CEUs should include information on differential diagnosis (e.g., dementia, AOD, etc.)
- Develop training tools for doctors and nurses that include the important role family plays in consumer care, as well as the unique stressors families face as caregivers.
- Develop training tools to address the tendency to blame the parents of consumers or stigmatize them for their children's mental illnesses.
- Require training for doctors on the use of psychotropic medications, including their adverse affects and interactions with other drugs.
- Provide training for consumers to teach them about their rights regarding medical record privacy.
- Require Community Clinics to have behavioral health components as a requirement for licensure.

Diagnosis and treatment

The workgroup identified several actions specific to the diagnosis/treatment of mental health issues by primary care physicians and nurses. Specific actions included:

- Create (or include within existing) medical assessment tools specifically to diagnose mental health problems in older adults. This will help address the stigma that dementia and Alzheimer's are a normal part of aging, as opposed to mental health issues in their own right.
- Revise diagnostic tools to look at "health and wellness" instead of physical health issues *or* mental health issues (e.g. ICD vs. DSM).
- Raise the profile of looking at, screening for, and addressing mental health issues in the context of getting *medical care* as opposed to *mental health* care

Mental/Physical Health Parity

The workgroup determined that the disparity between physical healthcare and mental healthcare is in itself stigmatizing. The integration of primary care and mental healthcare is critical for addressing this problem. "Health and wellness" rather then physical *or* mental health should be the main driver of the medical system. Specific actions include:

- The integration of community health clinics and mental health services. Community health clinics serve as the first point of contact with the health care system for many consumers, and can provide early intervention/detect first breaks.
- Eliminate preauthorization requirements in health care settings to provide or refer for mental health services.
- Revise "same day reimbursement" requirements for primary care clinics to provide mental health services on the same visit as primary care.
- Review and modify policies that restrict primary care providers' ability to serve people with mental health problems or those in crisis. "Primary care" providers should also include non-traditional providers with training such as faith-based/community based organizations).

- Establish an ongoing collaborative (that includes primary care providers) to continue working on stigma and discrimination reduction.
- The Department of Mental Health should develop partnerships with/liaisons to primary care associations, health insurance companies, and public healthcare agencies to reinforce the idea of "health and wellness."
- Establish consultation relationships between primary care and mental health (e.g. primary care physicians consult with psychiatrists for older adults with mental health needs).

Action Compliance/Enforcement

The workgroup agreed that responsible parties/enforcement mechanisms should be identified to ensure compliance with the actions discussed above. Specific actions included:

- Develop formalized recourse for consumers (such as an on-sight ombudsman) if physicians under treat their medical issues because the consumer also has a mental health diagnosis. At times, medical symptoms/complaints aren't believed, or are seen as mental health symptoms by physicians.
- The Department of Mental Health or other agency must ensure that parity between mental and medical health is being enforced. This agency should work with other public health agencies to expand parity wherever possible.
- Provide patients with information on patient's rights and the benefits of allowing them to exercise those rights.

Peer-to-Peer Support

Peer support is important in every facet of the medical/mental health interface. Peer-to-peer support actions included:

- Develop peer-to-peer self help support groups for medical issues at medical providers.

III. Mental Health System (Dorian & Christal)

The mental health system is designed to help people living with mental illness to live a better life. Service providers, consumers, and family members interact regularly within the system. For consumers and family members, however, the system itself can be a source of stigma and discrimination despite its good intentions. Consumers regularly express feeling dehumanized when they enter the system, and being treated as if they are fundamentally and irreconcilably different from the people serving them. For consumers, this dichotomy between people living with and without mental illness is itself false and misleading; mental health is seen as a continuum, with everyone moving between and occupying different spaces along that continuum at different times in their life. Family members regularly express feeling shamed and blamed for illness, and being treated as if their experiences are invalid and do not count. For both consumers and family members with different cultural backgrounds, the conceptual framework for understanding and treating mental illness as an individual condition can be at odds with the beliefs and practices of their cultural communities, where social bonds and support are paramount. In these ways, the mental health system can discourage those it seems to help from seeking treatment and recovering.

Consumers and family members seek to reduce stigma and discrimination in the mental health system by reframing their interactions with service providers. They emphasize being treated as

whole, dignified people, not medical specimens. They want their capacity for recovery to be recognized and actively supported, and feel peers should play a major role in designing and running systems of care. They desire choices and a direct say in the approach taken to treat them; treatment in all parts of the system should be voluntary. Family members desire respect and to have their lived expertise honored. Culturally appropriate services must be provided throughout the state, and the concept of mental health rethought to emphasize community integration, belonging, and inclusion. In this vision of California, the mental health system is a tool for the self-actualization of consumers and strengthening of families and communities.

EMPLOYMENT RECOMMENDATIONS

1. Provide equal opportunities for the meaningful employment and professional development of consumers in the mental health system.
2. Increase the presence of consumers in management and leadership positions in the mental health system.

EDUCATION RECOMMENDATIONS

3. Better prepare mental health professionals (including but not limited to nurses, doctors, providers, first responders) to work with people with mental illness by improving their graduate training curricula, including training about mental health consumer culture.
4. Involve mental health consumers in developing and delivering education about stigma and discrimination to professionals and communities.
    a. For example, the NAMI Provider Education Course.
5. Require periodic, ongoing training for professionals who work with mental health consumers.
    a. For example, the What Mental Health Professionals Need to Know series of conferences and lectures.

AWARENESS RECOMMENDATIONS

6. Advertise stories where consumers and professionals in the mental health system have positive and respectful relationships. For example, Canada's You Know Who I Am program.
    a. Sharing individual stories can change people and raise their awareness.
7. Support the establishment of Community Awareness Committees in every county to reduce the stigma associated with mental illness.

INTEGRATION AND COLLABORATION RECOMMENDATIONS

8. Integrate medical care and mental health care, including non-traditional providers and agencies, so both types of services can be provided at the same time.
    a. For example, primary care providers that are federally-qualified health centers.
    b. Non-traditional treatment settings can be less stigmatizing.
9. Fund community health centers that provide integrated services.
10. Foster collaboration and integration between community-based organizations that work on mental health issues.
11. Create university internships for students to work in MHSA programs.

FUNDING RECOMMENDATIONS

12. Evaluate current mental health service programs and reallocate funding to those which adopt the new way of thinking about and treating mental illness described in the introductory paragraph.
    a. Include consumers in the process of evaluating services.
13. Allow counties greater discretion in allocating MSHA funding so that outpatient services are not overemphasized.
14. Redirect resources to prevention and to recovery program.

INVOLUNTARY TREATMENT RECOMMENDATIONS

15. Encourage consumers to seek treatment by reallocating MHSA funding for involuntary treatment to alternatives like crisis centers, particularly those that are consumer-run.
    a. Fear of and stigma associated with arrest and involuntary treatment prevent many consumers from seeking any treatment whatsoever.
    b. No involuntary treatment anywhere.
16. Review county regulations on involuntary treatment and shift decision-making authority to people who know the clients, and include clients in decision-making.
17. Foster the appropriate emergency treatment of mental health consumers by shifting liability for supervision from law enforcement officers to appropriate professionals and facilities.
18. Ensure that mental health-related emergency calls are redirected from police first responders to licensed clinicians with adequate training and capacity for responding.
    a. Law enforcement officers have on average 20 minutes to respond to a call, and are not able to treat people living with mental illness adequately in such a short time.
19. Ensure that police are paired with licensed clinicians when responding to mental health-related emergency calls.
    a. Mental Health Mobile Evaluation Teams (METs) are an example of such pairing.
20. Build partnerships so that mental health consumers in crisis can be brought in by police officers and then evaluated for 5150 by licensed clinicians before any action is taken.
21. Reallocate a portion of emergency response funding to increase the number of licensed clinicians available to respond to and evaluate mental health emergencies.
22. Recognize that while involuntary treatment can ensure public safety and prevent tragedies and crimes in specific situations, it must be fully justified and properly used.
    a. In minority communities, involuntary treatment can be the only way people living with mental illness enter the system.

COURT SYSTEM RECOMMENDATIONS

23. Educate judicial officers about mental illness diagnosis, risks associated with mental illness, recovery from mental illness, and evidence-based best practices for sentencing.
24. Reduce mental health discrimination and tailor services to consumers by integrating family, drug, homeless, and probation courts with mental health courts.
    a. An example is SAMHSA's Prevention Pathways.
25. Promote the establishment of collaborative courts that promote accountability by combining judicial supervision with rehabilitation services that are rigorously monitored and focused on recovery.
    a. Recognize that collaborative courts are distinct from "calendaring" cases of a similar nature together in the regular calendar of a single judge, and from mental

health/probate calendars that deal primarily with probate/estate matters and conservatorships.

26. Promote access to services at the lowest appropriate level.
    a. Jails and prisons are expensive.

IV. Mental Health System (Susan & Nicole)

This write up has three major sections:

I. REDUCING STIGMA & DISCRIMINATION WITHIN THE OVERALL MENTAL HEALTH SYSTEM

II. REDUCING STIGMA & DISCRIMINATION TOWARD ETHNIC AND RACIAL COMMUNITIES

III. PREVENTING THE USE OF FORCE TOWARD INDIVIDUALS EXPERIENCING MENTAL HEALTH CRISES

I. REDUCING STIGMA & DISCRIMINATION WITHIN THE OVERALL MENTAL HEALTH SYSTEM

1. Develop and implement a range of specific strategies within the mental health system to make recovery and wellness the preeminent model for services and relationships with clients and family members. Corollary recommendations include:

a) Deepen the understanding within the mental health system, particularly among providers, policy-makers and advisory bodies, that recovery and wellness models are based on the innate potential of persons living with mental illness to heal, to make self-determined and informed choices about their treatment, and lead independent, productive and fulfilling lives. The recovery and wellness model emphasizes the use of strength-based assessments, treatment and service programs.

b) Establish recovery, wellness-oriented and rehabilitative services as the standard of care in the mental health system and incorporate this approach into mental heath provider degree and credentialing programs.

c) Develop a unifying definition of recovery and wellness and specify particular services and methods that promote recovery and wellness. Include clients and family members in this definition and specification process.

d) Change the language of mental health services and treatment from mental illness-oriented to recovery and wellness-oriented. This language would honor the universality of such human conditions such as fear, anxiety, depression, and panic

and reduce the use of stigmatizing terms applied to consumers and family members (e.g. border-line; enmeshed; symbiotic, over-involved; histrionic, etc).

e) Develop and conduct training programs for mental health providers to learn more about strength-based recovery model, to enhance their recovery-based treatment methods, and to establish recovery-oriented and rehabilitative services as their standard of care. Incorporate clients and family members as part of the teams that conduct these trainings.

f) Develop "contact" programs between providers, consumer and family members that build the interactions on an equal-status basis. For example, establish client-run training programs for mental health service providers on recovery and wellness methods.

g) Establish programs to promote dialogues among consumers and providers regarding recovery and wellness. Establish similar dialogues among consumers and family members.

h) Promote recovery and wellness models to consumers, families, policy-makers and the public at large by:

    i. Establishing programs to promote active dialogues among family members and consumers regarding recovery and wellness.
    ii. Developing a series of self –help tools for use by consumers and family members and offer more treatment and service programs for consumers that are self-directed.
    iii. Provide information and training to policy-makers and advisory boards on recovery and wellness models.

2. Establish peer-to-peer services as a routine component of systems of care.

a) Dramatically increase the numbers peer-run mental health programs, both voluntary and ones operated by clients paid to manage the service.

b) Use peer-to-peer programs as vehicles for building the capacity of consumer as well as to build partnerships among consumers, families and providers.

c) Integrate peer-to-peer methods into workforce development strategies.

3. Increase the numbers of mental health providers, especially those from communities and populations living with double stigmas (e.g. ethnic and racial communities, LGBTQ) and/or from communities with special needs (older adults, veterans, rural.)

4. Develop public and system-wide awareness that providers of mental health also are stigmatized and that stigmatization is most visibly demonstrated by the lack of resources provided to the mental health system. Corollary recommendations include:

a) Provide resources to increase the mental health services and workforce.

b) Increase the pay and training opportunities for mental health system personnel, particularly providers of services.

c) Develop programs to assist mental health providers to address the stress caused by the demands of their work.

d) Expand public reimbursement programs and private medical insurance to cover the service costs of a wider range of mental health providers.

e) Revise government policies to allow primary care FQHCS to provide mental health services and to be able to be reimbursed for services provided on a same day basis.

f) Allow Medi-Cal providers to be able to apply for Rehab Waivers

5. Provide mental health services at sites that carry less of a stigma for consumers and family members, for example primary care physicians, medical offices, community clinics, school counselors, etc. This also has the important benefit of integrating the medical and mental health service systems.

a) Co-locate medical, mental health and other social services at the same site. This is particularly helpful for the older adult population.

6. Review mental health systems' polices and practice to identify and then correct stigmatizing and discriminatory behavior toward consumers and families.

a) Seek out the guidance from consumers, families and communities on how to reduce stigma and discrimination.

b) Develop programs to acknowledge and reduce mental health stigma and discrimination toward family members.

c) Increase the numbers of consumer and family members on MHSA boards and advisory entities. Establish weekend and evening time slots for MHSA public briefings that are now done during typical work-time hours.

7. Provide information for consumers and family members on how to navigate the mental health system as one way of combating self-stigma.

II. REDUCING STIGMA & DISCRIMINATION TOWARD ETHNIC AND RACIAL COMMUNITIES

1. Increase the provision of culturally competent mental health services. Ethnic and racial communities experience less stigma when services delivery is appropriate to their culture. Corollary recommendations include:

a. Develop information that documents effective practices for specific ethnic and racial populations and distribute this information widely within the mental health, public health and medical systems.

b. Allocate and protect funding for culturally competent services. Too often culturally appropriate services are the last to be implemented and the first to be eliminated in economic down-turns.

c. Develop and conduct training programs for mental health providers in cultural competency, which includes a component that assists providers in understanding their own biases and stigmatizing attitudes and behaviors toward consumers and families from ethnic and racial communities.

d. Establish an effort comprised of representative from diverse backgrounds, experiences and expertise to review and revise the current definitions of recovery and wellness so that these concepts are culturally-sensitive and include ethnic and racial communities' perspectives, beliefs and visions of mental health, wellness and recovery.

e. Promote respect for and acceptance of traditional and cultural forms of healing within ethnic and racial communities. These forms of healing are not considered "alternative" by ethnic and racial communities. De-valuing such methods is not helpful to recovery and wellness for individuals from ethnic and racial communities.

f. Develop uniform standards to more objectively measure culturally competent services. Process indicators of cultural competency are not useful as they do not focus on outcomes, but rather on numbers and through-puts. Standards can lead to more accountability and transparency.

g. Conduct an assessment of the current mental health workforce to determine its capacity to serve ethnic and racial communities.

h. Increase the numbers of mental health professionals from ethnic and racial communities through aggressive workforce development programs. Mental health professionals should reflect the ethnic and racial make up of the communities they serve. Ethnic and racial mental health providers should proportionally reflect the ethnic and racial population make-up of California.

i. Hire more consumers and family members from ethnic and racial communities to work within the mental health system.

j. Substantially increase the number of ethnic and racial representatives with mental health expertise who sit on state and local mental health policy boards, commissions and other policy-making bodies, including the policy and advisory bodies related to the implementation of MHSA.

2. Provide equitable allocation of and access to mental health resources and services to ethnic and racial communities, along with accountability measures to ensure disparities are rectified as one of the mental health systems' highest priorities. Increase the recognition within the mental health system, among policy-makers, and other societal systems that individuals and families from ethnic and racial communities who seek mental health services face a double stigma. This double stigma leads to a severe lack of mental heath resources and services within ethnic and racial communities. Corollary recommendations include:

a. Conduct assessments and other studies to define the disparities (e.g. access, quality; availability; resource distribution, etc.) related to the mental health services provided to ethnic and racial populations and to identify ways to evaluate changes in the level of disparities over time.

a. Fund population-specific programs to address service disparities within the multiple ethnic and racial communities in California.

c. Evaluate statewide, local and other mental health system and organizational policies for biases and potential discrimination toward ethnic and racial populations.

3. Develop programs that engage ethnic and racial populations in their own communities and contexts to identify how to reduce stigma and discrimination toward individuals and families experiencing mental health problems.

4. Provide mental health services to ethnic and racial communities at a lowest level of intensity possible (e.g. primary care physician rather than a mental health clinic) as these types of services are considerably more acceptable to racial and ethnic communities and thus less stigmatizing. (Note to editors: Place this recommendation in Transitional Age Youth section directed at the TAY population.)

III. PREVENTING THE USE OF FORCE TOWARD INDIVIDUALS EXPERIENCING MENTAL HEALTH CRISES

1. Develop strategies to prevent the need for force and forced compliancy, including the use of restraints, seclusion, and unnecessary medication or medical interventions, in responding to perceived or actual mental health-related emergencies. This includes preventing the need for 5150s by law enforcement officers.

a) Develop and widely disseminate, through written information, trainings, seminars, inclusion in curricular programs and other communication vehicles, de-escalation approaches and techniques known to diffuse perceived or actual mental-health emergencies. Information on how to respond to trauma would be a key part of this effort. Information and education opportunities regarding de-escalation would be designed for potential first contact individuals including those from law enforcement, emergency and psychiatric response, clinicians and mental health providers, emergency room personnel, homeless shelters, outpatient medical, families, and others in a position to be a first-responder in a mental health-related emergency,

b) Fund residential and other crisis intervention programs that provide response personnel with alternatives sites for individual experiencing a mental health crisis other than jails, hospitals, emergency rooms and other similar facilities. There are several very successful programs in California to use as models, including

c) Provide resources for law enforcement and other emergency response personnel to have immediate access to mental health clinicians, skilled in de-escalation and mental health emergency evaluation, who can accompany responders to a mental health-related emergency. Mental Health Mobile Evaluation Teams (METs) are an example of such a program. If a clinician can not accompany the first responders to the emergency site, arrange for a trained clinician to be available to talk with and evaluate the status of the individual in crisis before any legal, site transfer, or other action is taken. In all of these situations, emphasize the need for shared-decision making with the individual in crises, and their family as appropriate.

d) Integrate peer support from mental health consumers into the programs and operational protocols of agencies responsible for responding to mental health-related emergencies.

e) Work with local emergency response agencies to identify situations where mental health-related emergency calls can be directed to trained clinicians rather than traditional first responders.

f) Initiate an effort to review and revise county regulations and first responder protocols regarding emergency response to prevent the need for force and forced compliancy in responding to perceived or actual mental health-related emergencies. In this review,

identify if individuals from ethnic, racial and other vulnerable populations (e.g. LGBTQ; youth, etc.) are treated differently than others and, if so, develop procedures for first responders to ensure that this does not continue. Along with this review, assess the potential for shifting the liability assumed by first responders in a mental health-related emergency to trained clinicians and mental health facilities as appropriate.

g) Develop and widely disseminate a synopsis of state and county laws and regulations on involuntary mental health care to emergency response personnel, emergency room personnel, hospitals, outpatient medical facilities, mental health professionals, families, and others who may respond to a mental health-related crises.

V. Housing

INTRODUCTION

Housing is a fundamental need. *Housing First* was a universal theme expressed by the Work Group of four service providers and mental health professionals. The alternative is homelessness, which carries its own stigma. Unfortunately there are many challenges to providing and acquiring appropriate housing for consumers. The Work Group was asked to identify actions that could be taken to reduce discrimination and stigma against mental health consumers with regards to housing. The group, with added input from other meeting participants, agreed that the following topics need to be considered:

- Community acceptance
- Availability of affordable housing
- Service Models
- Types of Housing
- Regulations
- Education
- Advocacy
- Success criteria
- *Housing First!*

The following actions were recommended to reduce stigma and discrimination resulting from housing issues:

COMMUNITY ACCEPTANCE

The public often fears what it does not know. Mental health issues are easily ignored behind a shield of NIMBY-ism due to public fear and ignorance. Introducing the community to consumers gives the public a chance to meet and interact with individual consumers, allowing them to better understand mental health issues. This engagement hopefully leads to reducing discrimination and stigma. The Work Group recommended the following actions:

1. Reduce stigma and discrimination by bringing mental health providers, community members, residents/tenants, and developers/property managers together from conception

through to the completion of the housing project. Increased interaction promotes understanding and reduces stigma and discrimination.
2. Take elected officials on tours of developments and service delivery models to introduce them to the facilities in their areas, the consumers utilizing the facilities, and the special needs of consumers. Educating elected officials is an important step in stigma and discrimination reduction.
3. Invite and utilize volunteers to assist at mental health developments. One model cited is "Gardening Angels" – community members who volunteer to work with consumers on a community garden at a given housing development. Gardening builds community. The interaction between community members and consumers reduces stigma.
4. Bring community professionals (ex. physicians, dentists, etc.) to mental health developments to improve interactions. Consumers, fearful of discrimination, can be reluctant to venture outside the development to obtain needed services from unknown providers.
5. Create opportunities for consumers to interact with the community. An example provided was utilizing consumers to distribute disaster preparedness information to residents in their neighborhood.

FUNDING

Funding is at the heart of delivery of housing services. Without funding, there is either inadequate or insufficient housing. Homeless populations are heavily discriminated against. To reduce discrimination and the stigma of homelessness, the Work Group recommended the following actions:

1. Establish a permanent funding source for affordable housing. Sponsor or support a legislative campaign for a permanent funding source.
2. Leverage the Mental Health Agency's funding to smooth out the spikes and gaps in variable funding streams.
3. Transform funding and disassociate it from site control and development priorities. Development priorities do not always match consumer's needs.
4. Create a single-source funding stream to facilitate the creation of housing by mental health agencies..
5. Simplify the process to use existing housing rather than building new housing. Currently the emphasis is on new development. Not only does it take more time to develop the property, but the current economic crisis has tightened credit - resulting in substantially fewer new development starts. There is a glut of existing housing that could be modified economically and expeditiously to meet the increase in demand.
6. Once housing is established, fund support services to ensure housing is maintained.

TYPES OF HOUSING

To reduce both discrimination against consumers, and the internal stigma experienced by consumers, appropriate housing is fundamental. The Work Group recommended the following actions:

1. Meet consumers immediate housing needs (whether transitional, permanent, or emergency housing) to reduce the stigma of homelessness.
2. More completely integrate mental health housing into communities so as not to "billboard" consumers.
3. Promote mixed population housing to reduce sigma and promote acceptance.
4. Promote permanent housing to normalize living environments and change community perceptions. The goal is to eliminate stigma.
5. Don't forget people "at risk" whose families need respite and supported housing for their family member.
6. Separate housing to provide specific services to specific populations.
7. Provide separate housing opportunities for young adults and older adults. Involve the young adults in the planning and development of ideas.
8. Provide housing options and funding for individuals with co-ocurring disorders/issues (e.g. substance abuse and mental health challenges.)

REGULATIONS

The world of mental health is governed by regulations. Regulations can work to support or prevent adequate housing. The Work Group recommended the following actions:

1. Analyze/study points of conflicting regulations at local, state, and federal levels. In some cases, accepting benefits from one program prevents eligibility in other programs. The example cited was acceptance of emergency housing rendered the consumer ineligible for long-term Section 8 housing.
2. Advocate to HUD for clear and consistent interpretation of regulations. This would lessen the likelihood of different interpretations by local agencies.
3. Change policies that are too lax – particularly ones that make it too easy for cities and counties to acquiesce to NIMBY-ism.

EDUCATION

Reduction of discrimination and stigma can best be achieved by education. Surprisingly, not just the public needs to be educated, but also regulatory agency staff, service providers, property managers, and even consumers. The Work Group recommended the following actions:

1. Request the Department of Mental Health produce and disseminate guidance documents on stigma and discrimination to mental health clients in housing.
2. Educate the Department of Mental Health to not stigmatize consumers within housing.
3. Require that borrowers of State Housing funds must have property managers attend DMH sponsored training on mental health issues and reduction of stigma and discrimination.

4. Educate Housing Authority staff on mental health issues. Obtaining housing is not the end of the story for mental health consumers. Additional services are required for maintaining residency.
5. Create more opportunities to socialize and transition 30 – 50 year olds from institutionalized or board and care facilities to independent living.
6. Educate stakeholders and advocates.
7. Educate renters and landlords about their mutual responsibilities.

ADVOCACY

Consumers are not always able to resolve housing issues by themselves, often leading to self-imposed internal stigma. Advocacy can support consumers by providing direct assistance, or by providing a consumer-friendly system. The Work Group recommended the following actions:

1. Create a Department of Mental Health Ombudsman position to assist with consumer housing issues.
2. Create cross-training for mental health advocates to understand Fair Housing issues, and Fair Housing advocates to understand mental health issues.
3. Create management level advocates within the Department of Mental Health and Fair Housing that will promote the effectiveness of peer-to-peer services.

SUCCESS

How do you measure success? Can housing create healthy communities? Unfortunately the Work Group ran out of time before these questions could be answered and actions developed.

VI. Employment and Workplace

INTRODUCTION

Mental health consumers in the workplace face a number of challenges that non-consumers do not. These challenges extend throughout the application/pre-employment process and into the every day tasks of employment. In addition to the negative view of mental health problems held by many non-consumers, consumers in the workplace may suffer from a self-stigmatizing view of any performance challenges they may have.

While stigma and discrimination in the workplace are significant challenges for consumers, employment itself can be a major factor in the recovery process. Creating employer awareness of mental health issues is critical for the success of consumers in any job. Employer education that consumers are an asset to the company is very important, and company "wellness" campaigns should focus on overall health, including mental health training similar to ergonomics adjustments.

Specific actions include:

Employment in the Mental Health Field

- Establish positions for young adult consumers at the county level that are "real" positions and not token jobs. Policies should have clear expectations on what can be offered to

younger people. This will help young consumers develop work experiences that they will be able to carry with them for there entire lives.
- Develop policy guidelines (within organizations and at the state level) that recognize the benefit of hiring consumers with real life experience for mental health positions.
- Hire consumers for positions other then typical "consumer" jobs.
- Train the mental health workforce in "client culture."
- Use peer support groups within the mental health system for consumer employees.
- DMH should create a consumer mental health liaison to the California Department of Rehabilitation.
- Assign one DMH staff member to county mental health departments and school districts.

Internal Company Policies

- Company personnel policies should see consumer life experiences as a desirable quality.
- Develop employee education about the necessary accommodations for mental health issues. Mental health training must highlight consumer success stories and acknowledge that they are part of the workforce.
- Mental health issues should be addressed from a business/profit perspective: providing consumers with peer support opportunities cuts treatment costs and boosts productivity.
- Develop internal company policies on disability discrimination and harassment that include illustrative examples of the consequences for breaking those policies. DMH should create a model to role out this policy.
- Recognize Certified Psychiatric Rehabilitation credentials for Medi-Cal Reimbursements.

Employment Partnerships

- Private companies should interact with the mental health system to develop a consumer workforce development system.
- Examine the recommendations from the Consumer Employment Summit in 2008. A report from the Summit can be found online at http://cmhda.org/go/MentalHealthServicesAct/WorkforceEducationandTrainingWET.aspx.
- Utilize existing partnerships like the Workplace Partnership for Mental Health; www.workplacementalhealth.org.
- Develop partnerships between organized labor and existing consumer advocacy groups.
- Use the example of programs like "Us+Them=We" in San Bernardino County to bring working and non-working consumers together in the workplace.
- Partner with local chambers of commerce to develop anti-stigma/discrimination material.
- Investigate the Business Leadership Network for partnership opportunities.
- Senior employment programs could benefit from a partnership with mental health programs serving seniors.

Funding Issues

- California should apply to Medicaid for workplace rehabilitation funds. Peers can bill for services within the workplace to maintain treatment flexibility.

- Fund contract programs within many types of organizations.
- Maintain adequate funding levels to ensure that new consumer employees can be hired for MHSA positions, instead of keeping existing staff employed and shifting them to the MHSA.
- Dedicate funding for ongoing mental health treatment and peer support once a consumer is hired. To reduce costs, utilize technology such as web conferencing in rural areas.

Training

- Train consumers currently in recovery for professions in police, paramedic, housing, and other public safety professions.
- Use older adults to promote training regarding mental illness/mental health.
- Use peer trainers to put on "mental wellness" training in the workplace. The University of Southern California has funding available for consumers to "train trainers". Due to county budget restrictions, private programs like this should be utilized wherever possible.

Other

- Workplace stigma and discrimination reduction training should be flexible enough to apply to small businesses and large corporations.
- Investigate the AOD system, which integrated "recovery" many years ago.
- Create self employment options for consumers to avoid the issues of stigma and discrimination. Self employment provides consumers with the scheduling flexibility they may need when issues arise.
- Develop statewide policy changes regarding the licensing or background checks used for employing a consumer with past criminal history.
- Create opportunities for job sharing
- Document empirical evidence regarding the benefits of consumer employment and personal testimony.
- Stigma reduction campaigns should include employment issues related to family members.

Cultural Competency

- Recognize and provide extra support for ethnically diverse consumer staff to ensure their success in the workplace.
- Recognize that consumers/family members of color may need more support then majority consumers.
- Develop "culturally competent" concepts to accurately reflect the proportion of staff with disabilities.

VII. Media

Participants in the media workgroup expressed deep concern that the public perceives people with mental illness as more violent than the overall public. However, in fact according to data this is not true. To combat this misperception the group recommends that alternative non-violent representations and information about people with mental illness be promoted in media. The

term “violent” may not be a label that applies to all populations, such as children, where instead words like “weird” or “nerd” may be used.
The various types of media including multi-media, alternative media (games, podcast, blogging, web) community media, commercial media, as well as film and televisions are all important in addressing stigma and discrimination reduction. Contact with the media should include proactive as well as reactive efforts. Some types of media may be more helpful in targeting particular populations such as alternate media in reaching youth or AM radio for some parts of the Latino community.
Big media campaigns can be expensive and research has not necessarily shown them to be particularly effective. The group recommends using grass roots and bottom up media approaches to target specific populations taking into consideration the differences in how ethnic communities and age groups may define mental illness. These grass roots efforts also offer the benefit of getting the client voice heard in the community as well as reaching transitional age youth and other marginalized groups. The power of television shows and films to reduce stigma and discrimination was also discussed.

DRAFT RECOMMENDED ACTIONS ON MEDIA

COMMUNITY BASED EFFORTS

1. Develop ethnically and culturally relevant grass roots and bottom up media efforts targeting specific populations, including opportunities for client voices to be heard in the community.

2. Develop drop-in media centers for youth, homeless, and low-income people, and communities of color. Examples are: Road Dawgz Youth Drop-In in San Francisco & Silicon Valley DeBug in San Jose.

COUNTY EFFORTS

3. Develop county specific lists of clients and family members to provide media with personal stories and information on mental illness and recovery.

4. Drive and inform statewide efforts based on media efforts in the counties.

5. Develop increased ties with community- based media and increase utilization of public service announcements.

STATEWIDE CAMPAIGN

6. Include consumers in the design, development, and evaluation of media efforts, leveraging ethnically and culturally relevant grassroots, bottom media efforts.

7. Utilize media and marketing professionals to complement the key role of consumers in the design, development, and evaluation of media efforts.

8. Address self-stigma in media efforts including information on self-help, recovery tools (e.g. WRAP), and self-acceptance.

9. Look at and borrow successful approaches from other campaigns such as reproductive health and AIDS.

10. Target media efforts to specific populations and feature individuals that will make an impact on that population.

Accountability

11. Develop a statewide mental health media ethics committee including: consumers, media, and mental health experts to respond and evaluate programming to reach out to local communities and media professionals and to develop a media ethics quarterly report.

Training

12. Develop media training for local communities on print and TV media including how to develop press releases.

13. Develop training for consumers to act as hosts for television and other media programs.

Ethnic & Cultural Communities

14. Ensure that differences in how various ethnic groups define mental illness is reflected in media efforts.

15. Work to overcome any negativity that may exist between traditional media and some ethnic communities that may minimize effectiveness of media efforts.

16. Identify communication models to communicate with ethnic cultural groups.

Resources & Coordination

17. Set up an Office to work directly with media that:
    a. Fosters efforts such as cable TV's Cable Positive for HIV/AIDS.
    b. Assures media campaigns meet recommended standards.
    c. Work to coordinate with local county campaigns.
    d. Maintains website that includes/educates on wellness, signs and symptoms that is easily accessible to the media.
    e. Develop a statewide hotline 1-800 number for both clients and community that can provide on county-by-county basis resources and expertise.

18. Develop a statewide resource guide that is regularly updated and customized by county that includes names of people and FAQ's and resource lists.
    a. Include contacts such as: experts, local contacts, state level contacts, individuals experiencing mental illness taking into consideration need for media to have variety of contacts ranging from advocates to those that are neutral.

19. Cultivate Media Champions by creating a group of journalists, editors, writers, ethnic media, and consumer reporters who have shown interest in mental health and providing with short conferences to educate them on mental health. Use a catchy positive name for this group to encourage participation.

20. Connect media with client community events and other current events such as May is Mental Health Month.

21. Provide media with history and evolution of client movement and it's connection to civil rights and produce a documentary on the history of the client movement in California.

22. Develop outcomes for media campaigns resulting in *behavioral* changes among groups who are most likely to discriminate and contribute to prejudice.

23. Develop a video presentation for K-12 to address stigma and discrimination that features characters of interest to children such as action heroes reflecting how children experience stigma and discriminations.

24. Develop a depression awareness campaign targeting older adults to reduce stigma associated with depression, particularly older men that experience highest rate of suicide.

    a. For older adults use champions such as Patty Duke and Glen Close.

25. Provide *positive* feedback to media via letters, emails, honoring individuals, when see a positive, anti-stigma story.

26. Develop statewide use of college campus radio and campus websites to portray positive mental health messages and as a means for educating and raising awareness.

Film & TV Media

27. Support efforts to embed clients in soap operas or other programs.

28. Develop end of the program "tag lines" to provide information on where to get mental health information.

29. Seek to cross-promote with programs within networks.

Media Messages & Themes

30. Develop messages for media that promote alternative "non-violent" representations of people with mental illness including:

    a. "Take the crazy out of crazy"
    b. Consumers are all walks of life, not necessarily distinguishable.
    c. It's happening in my family too.
    d. "All" have mental health.
    e. "Mental health matters" (particularly important message for transitional age youth)
    f. "Depression is not a normal part of aging"…"Talk with your doctor"

g. Talking about civil rights issues when address stigma and discrimination.

VIII. Law Enforcement

The law enforcement system is designed to ensure public safety and protect people in crisis from themselves. The interface between law enforcement officers and people living with mental illness, however, can be tense, especially given existing constraints on an emergency call and response. Officers have limited training, resources, and particularly limited time to serve people in crisis, yet mental illnesses are complex, diverse, and manifest differently in different people. Compounding these acute factors are the societal stereotypes, fears, and debates about people who live with mental illness, and pressure to "do something." At the same time, mental health consumers are particularly vulnerable. They are more likely to be subject to violence than the general population, and those who enter the criminal justice system then face a double-stigma when they return to society. As a result, positive interactions between law enforcement and mental health consumers are irregular, and both groups continue to be criticized, stigmatized, and harmed by society and by each other.

Improving the interface of law enforcement, mental health consumers, and their families must recognize this social context. In discussions it was noted that California shifted the responsibility for mental illness from mental health institutions to law enforcement in 1969. A central question is whether California has realistic expectations of law enforcement, and whether law enforcement's existing responsibilities and liabilities for mental health crises are appropriate.

Given the current responsibilities of law enforcement, consumers and family members seek to reduce stigma and discrimination by reframing their interactions with law enforcement personnel. The fundamental starting point is that both consumers and officers are human beings that deserve to be treated with respect and dignity, rather than stereotyped. Both consumers and officers are diverse groups of people, and cannot be lumped together as if they were all the same. People in both groups have been developing new ways of thinking and new ways of interacting that need to be recognized and supported. Issues of restraint and incarceration remain contested. But both groups agree on the need for new approach emphasizing long-term solutions, community-oriented policing, peer support, and partnering with mental health service providers and professionals.

EDUCATION AND TRAINING RECOMMENDATIONS

27. Require mandatory training for law enforcement officers, from the highest through the lowest levels, including basic training at the police academy, on the following topics: sensitivity training; stereotype avoidance (particularly regarding violence); display behavior recognition; de-escalation techniques; and avoiding 5150.
28. Involve consumers and also families in designing and delivering education and training.
29. Train law enforcement officers to write case reports that emphasize appropriate diagnosis.
30. Require all State, county, and municipal law enforcement agencies to establish Crisis Intervention Teams as a best practice for increasing awareness and improving diagnosis of mental illness, thereby reducing violent interactions.
    a. Santa Clara County has had marked success with this approach.

b. This is not feasible statewide. Other proven practices need to be in the plan. See Stafford, S. Policy Framework for Law Enforcement thesis available in CSUS Library.

31. Make the Peace Officers Standards and Training a statewide association.
32. Establish community education programs that cover a range of law enforcement interactions – not just criminal acts – and link mental health staff, consumers, families, and underserved and un-served populations.
33. Establish two-way training programs so law enforcement can learn about mental health issues at the same time as consumers, mental health providers, and communities learn about law enforcement mandates and constraints.
34. Establish peer-to-peer support groups for police officers

COLLABORATION RECOMMENDATIONS

35. Ensure that police are paired with licensed clinicians when responding to mental health-related emergency calls.
    a. Mental Health Mobile Evaluation Teams (METs) are an example of such pairing.
    b. When an emergency response includes police officers a community may feel stigmatized.
    c. Response teams should be created that do not involve police officers.
36. Ensure that police officers who respond to mental health-related emergency calls disclose their identity and status.
37. Create a Police Dispatch Checklist which identifies whether a mental health issue is involved and provides a mechanism for pairing officers with licensed clinicians in real-time response.
38. Ensure that mental health-related emergency calls are redirected from police first responders to licensed clinicians with adequate training and capacity for responding.
39. Foster direct dialogue between peer and advocacy groups and law enforcement officers about best practices for emergency response.
40. Partner with trained mental health providers to provide services for incarcerated consumers.
    a. UC Davis' partnership with the city provides an example.

AWARENESS RECOMMENDATIONS

41. Share examples of positive interactions and relationships between law enforcement and mental health consumers with families and communities.
    a. The City of Santa Monica and NAMI both have some great examples of mutual education, partnerships, and improved quality of life for consumers.
    b. Some law enforcement officers have significant experience with mental health consumers and treat them with dignity, respect and sensitivity.
42. Support the establishment of Community Awareness Committees in every county to reduce the stigma associated with mental illness.
43. Ensure that media coverage of mental health emergencies documents law enforcement actions in a clear and unbiased manner.

INCARCERATION RECOMMENDATIONS

44. Establish voluntary urgent care clinics as an intermediate step between emergency psychiatric services and jail.
45. Provide mental health consumers who are leaving jail with case management, relocation, housing, and employment support.

a. The PALS program is an example.

LEGAL RECOMMENDATIONS

46. Conduct a comprehensive reexamination of existing State and local government laws and ordinances for legal forms of discrimination and civil rights violations.
47. Compare the effectiveness of city ordinances that address homelessness.
    a. Sacramento's recent ordinance allowing homeless camps is an example.

COURT SYSTEM RECOMMENDATIONS

48. Reexamine statutory and legal definitions of "dangerousness" to differentiate between low-level misdemeanors and more serious offences.
49. Expand the number of mental health courts in California.
50. Involve mental health consumers in the development and formation of court programs that help people seek services and reintegrate with their communities rather than going to jail.
51. Support court programs that promote individual responsibility and accountability by providing treatment resources and allowing consumers to make their own choices.
52. Establish a state policy for prosecuting mental health consumers at the lowest appropriate level.
    a. For example, differentiate between someone who steals bread because they are starving, and someone who has committed a violent attack.
53. Ensure the integrity, oversight, and accountability of the court system.

COMMUNITY ORGANIZING RECOMMENDATIONS

54. Support the formation of diverse, community-based mental health coalitions that advocate for the integrity, oversight, and accountability of law enforcement as related to mental health.
    a. San Jose's Coalition for Justice and Accountability is an example.
55. Establish mechanisms for the legal oversight by parole officers, families, and communities of law enforcement efforts involving mental health consumers.
56. Promote opportunities for meaningful, regular dialogue between community mental health organizations, law enforcement, and mental health providers about ways to improve institutional responses to mental health emergencies.

FUNDING RECOMMENDATIONS

57. Analyze the effectiveness of law enforcement programs and reallocate resources to those that adopt the aforementioned new approach.

PROCESS RECOMMENDATIONS

58. Regarding this process, review each Law Enforcement recommendation in light of the Actions from the Workgroup on Children (v1, 1/28/09)

IX. Law, Public Policy, and Legal System

INTRODUCTION

Consumers and Mental Health Professionals are aware of inequities in the availability and delivery of services. These inequities are often discriminatory. They also cause stigma – external as well as internal, self-imposed stigma by consumers who feel discriminated against. The Work Group of nine consumers and mental health care professionals considered the following topics:

- Policy Issues
- Legislation
- Education
- Enforcement
- Institutional Discrimination (both age and class)

During the gallery walk, a suggestion was added to look at the law and public policy through the lens of *Actions from the Workgroup on Children version 1 (1/28/09).*

The following actions were recommended to reduce stigma and discrimination resulting from the law, the legal system, and public policy:

POLICY

Policies are intended to support consumers, programs, and delivery of services. Occasionally policies can lead to unintended consequences of stigma and discrimination. The Workgroup recommended the following actions to amend current policies.

7. Develop separate and detailed personnel polices for state (DMH) and local agencies to prevent harassment and discrimination based on:
    a. Disability
    b. Age
    c. Race
    d. Gender
    e. Sexual orientation
    f. Gender identity and expression
    g. Religion

    Include enforcement, accountability and consequences within the policy. This policy should become the model for all state agencies. In addition, DMH should model this policy for all agencies, organizations, and consumers.

8. As a condition of MHSA or other mental health funding, require periodic review of anti-discrimination policies (and the implementation of the policies) of protected classes – or risk loss of funding.
9. Develop policies regarding seclusion and restraint:
    a. Eliminate seclusion and restraint. It stigmatizes consumers.
    b. Require certified peer advocates intervention when a consumer is under seclusion and restraint.
    c. Allow designation of a family member or friend who is allowed to visit the patient in seclusion and restraint.
10. Define the vague elements of "medical necessity" in the DMH guidelines on serving consumers who meet medical necessity criteria. Medical necessity rules are problematic in so far as they elevate clinician's diagnostic assessments while invalidating client's self-assessed needs and issues.

11. Require DMH to develop statewide medical necessity minimum standards.
12. Re-evaluate the purpose behind managed care mental health guidelines.
13. Revise the 5150 policy to:
    a. Allow access of care between one's primary care physician and the psychiatrist.
    b. Allow consumers to refuse care from student interns and residents. Allowing control over one's self reduces self-imposed internal stigma.
    c. Allow clients to refuse forced treatment, including during the 72-hour hold, including weekends and holidays. Clients are routinely force-administered antipsychotics at the initial point of entry.
14. Create parity of patient rights between mental health and physical health.
15. Develop cultural competency of consumer rights.
16. Require cultural competency expertise when developing [policy or planning] programs.
17. Remove social rehab facility from CCL and transfer to DMH. CCL staff are not equipped to handle the mental health population. Educating CCL staff on stigma and discrimination has been ineffective to date. The personal biases of CCL staff are creating problems for SRF's.
18. Repeal "quality of life" laws and ordinances at state and local levels that criminalize poverty and homelessness.
19. Support a statewide initiative to reduce stigma and discrimination in the workplace through development of mandatory posting requirements of material related to stigma and discrimination - similar to current requirements to post employment notices for minimum wages, workers comp, overtime, etc.
20. Recognize CPRP for Medi-Cal billing. This will reduce stigma and discrimination by giving consumers greater access to employment.
21. Include peer-to-peer self-help support groups as parallel elements of all types of service.
22. Limit the number of medications that can be prescribed to a patient to avoid over-medicating.
23. Develop a Transitional Age Youth system of care.
24. Encourage institutions to house Transitional Age Youth separate from children and adults.
25. Review sources of funding and how they are used to identify areas of duplication.
26. Develop assessment tools.
27. Develop a clearinghouse of resource materials.

LEGISLATION

The Work Group members believed that some inequities require legislation to correct and provide for enforcement. The Workgroup recommended that the following actions be taken to sponsor new legislation that would amend or promulgate new laws.

1. Modify state and WIC laws to restore civil rights for ex-offenders for licensing purposes.
2. Strengthen the protection of Prop 63 MHSA funds.
3. Sponsor legislation to develop a state-mandated system of care for older adults – distinctive from the adult system of care.

4. Require competent representation by Public Defenders for mental health consumers (e.g. conservatorship). Consider separate mental health courts or attorneys dedicated to mental health issues.
5. Develop legal alternatives to conservatorships.
6. Provide state funding to expand County patient's rights services.
7. Require the State to develop a viable Olmstead Plan.
8. Allow reimbursement for caseworkers in FQHCs – to assist with mental health conditions.
9. Allow for MFT reimbursement.
10. Develop a plan of action/strategy for "same day visit" reimbursement for both a primary care visit and a mental health visit. Memorialize in the FQHCs.

EDUCATION

Many of the Work Group members passionately supported the concept that disability rights are civil rights. The Work Group recommended the following actions:

6. Educate everyone to understand that Disability Rights = Civil Rights
7. Re-evaluate the purpose behind the medical necessity criteria. Document exclusions and restrictions.
8. If Counties restrict medical necessity more than the State criteria, then need to be transparent and explain what criteria is being used.
9. Encourage more coordination, communication, and collaboration between disability rights and civil rights groups.
10. Provide birth to adult education programs to treat the whole child. Consumers are more than test scores.

ENFORCEMENT

The Work Group felt strongly that disability rights should be enforced. In addition, several consumers believed that penalties should be assessed when rights are violated. The Work Group recommended the following actions:

1. Enforce disability rights as civil rights.
2. Develop an oversight entity to enforce accountability for discriminatory practices, including WIC violations. The goal is to promote, develop, and sustain equity in resource allocation and access to services.
3. Assess financial penalties when regulations are violated.

INSTITUTIONAL DISCRIMINATION

Discrimination is thought to occur as a result of an institution's policies and practices. The Work Group recommended the following actions to reduce discrimination and stigma:

Re-evaluate an institution's policies to reduce institutional discrimination. Specific polices to evaluate include:

- Enforce delivery of culturally competent services that reduce disparities within the system.
- Weave cultural competence, as well as oversight and accountability, throughout mental health, police, health programs, etc.
- Determine what mental health training is provided to prison personnel and what services are available to prisoners re: M.I. and AOD issues.

X. Faith-Based Organizations

Theme 1: Establish and/or enhance a regional multi-faith-based network throughout California.

- Action 1: Education of clergy personnel using existing models (e.g. Familias Unidas Saben)
  - Assess training needs
  - Training components:
    - Sensitivity of different religious beliefs/practices
    - Raising awareness of age-related issues
    - Raising awareness of mental health issues to clergy (to bring the message to the congregation or community)
    - *Posted Note Comment: Use "Shadow Voices" DVD and similar materials to raise awareness (Shadow Voices features consumers who have "recovered" or are in recovery, challenges faced by consumers "in the system," and a piece on faith-based issues)*
- Action 2: Use clergy personnel and or churches as a resource distribution site.
- Action 3: Include faith-based models when developing PEI promising practices. (survey communities for promising models)
- Action 4: Create a faith-based best practices category on existing or future resource site.
- Action 5- consider cross-collaboration with the faith communities, particularly for ethnic communities, whose faith may involve non-traditional or non-Christian faith communities in way that is most supportive of clients and their recovery.

Theme 2: Establish spirituality as a tool for wellness and recovery within the systems. Recognizing a client's faith as a support system and a resource for their wellness is an important component of service delivery.

- Action 1: Educating mental health providers about the value of spirituality in treating mental health conditions
  - Utilize the regional multi-faith-based network to provide insight on different beliefs/values that can inform treatment approaches and/or methodology.
- Action 2: Explore role/usefulness of spirituality during mental health assessment and provide resources as appropriate (e.g. listings of regional multi-faith-based network)